MHSOAC
MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

COMMISSION MEETING MINUTES
April 27, 2006

I. Call to Order, Roll Call and Minutes Approval

Chair Steinberg called the meeting to order at 2:00 p.m.

Present were Commissioners Carmen Diaz, F. Jerome Doyle, Saul Feldman, Linford Gayle, Mary Hayashi, Patrick Henning, Karen Henry, Gary Jaeger, Kelvin Lee, Andrew Poat, Darlene Prettyman, Darrell Steinberg.

Absent at roll call were: Commissioners Wesley Chesbro and Mark Ridley-Thomas

Tricia Wynne represented Commissioner Lockyer and Ann Sasaki-Madigan represented Commissioner Kolender.

Chair Steinberg asked for a motion to approve the minutes. He noted that the minutes should reflect one change regarding Senator Chesbro's comments on the strategic initiatives. Ms. Clancy said that Senator Chesbro wanted to ensure that the minutes reflect that the Department is not only accountable to the Governor, but to legislature as well.

MOTION: Motion carried unanimously.

II. Welcome, Purpose of Meeting

Chair Steinberg welcomed everyone to the meeting and thanked Stanislaus County for hosting the Commissioners. He introduced Jack Waldorf, Chair of the Stanislaus County Mental Health Board.

A slide presentation was given by Chair Steinberg entitled, "My Summer Vacation" depicting what is hoped to be accomplished at this month's meeting.

April 27 - The main item to be accomplished at today's meeting is to have an in-depth discussion about California's traditional mental health financing. Specifically, the Commission will look at how county mental health directors are addressing their financing challenges in three strategic directions: (1) reducing disparities; (2) increasing partnerships; and (3) making mental health relevant to the public.

This evening the Commission will tour a Wellness Center to learn about wellness recovery.

April 28 – At today's meeting the Commission will hear from client and family members. The next item on the agenda will be an update from Dr. Stephen Mayberg on the Department. The third item will be a presentation from Carol Hood regarding year two annual updates. Next item

will be the MHSOAC Committee Reports and updates. The fifth item will be public comment and lastly, the Commission will deliberate and take action on various implementation issues.

Discussion topics for future meetings will be discussed including, prevention around children's mental health, ongoing education about preventative mental health services, stigma reduction, foster care, co-occurring disorders, and Native American access.

III. Welcome from Stanislaus County

Mr. Waldorf welcomed everyone to Modesto. He said this afternoon the Commission will be visiting the Wellness Center and he believes everyone will enjoy the visit. He thanked the Commission for meeting in Modesto.

IV. California Mental Health Financing, 101 & Discussion

Patricia Ryan, Director of California Mental Health Directors Association provided the following presentation:

- The California Community Mental Health Services Act 1969 was a national model of mental health legislation that "deinstitutionalized" mental health services, serving people with mental disabilities in the community rather than in state hospitals.
- When the Act was passed in 1969, the Short-Doyle Act was the funding mechanism intended to build the community mental health system. Legislation and statute was developed that provided a framework for that community mental health system. Unfortunately, Governor Reagan vetoed the funding provisions in 1972 and 1973, so the state failed to distribute the savings that they thought would be achieved through the closures of state hospitals to the community mental health system.
- A fundamental issue to understand is that mental health services to people in the community was never created as an entitlement system and in California mental health services has never been an entitlement.
- In the Short-Doyle statutory language you often see "to the extent resources are available". So whatever funding is available to provide services at the local, it is to the extent that resources are available. So this has laid the groundwork for rationing of mental health services in California.
- The major sources of mental health funding today are: (1) realignment revenues; (2) state categorical funding, including AB2034, AB3632 and Medi-Cal EPSDT funding; (3) federal funding including SAMHSA and Medi-Cal FFP; and (4) Mental Health Services Act, which when funds are distributed will be an exciting new revenue source.
- Beginning with an inadequate funding base, state allocations to counties were severely diminished due to inflation throughout the 1970's and 80's.
- From 1982 to 1987 there were no cost of living or caseload adjustments to support community mental health.
- In 1990, California faced a $15 billion state budget shortfall which would certainly have resulted in even more drastic cuts to mental health. Community mental health programs were already near collapse and overwhelmed with unmet need. This crisis propelled the enactment of "Realignment".
- "Realignment" was enacted in 1991 with the passage of the Bronzan-McCorquodale Act and it took the funding of community mental health services out of the State General Fund Budget and revenues flowed directly to counties. This realignment represented a major new shift in financing for county mental health.
- The funding for realignment came from a new dedicated revenue source so the legislature passed an increase in sales tax and dedicated part of the State vehicle license fee to these

realigned programs. From the start, revenues fell short of expectations due to the recession.

- The mental health programs that were realigned from the State to the counties were all community-based mental health services, state hospital services for civil commitments, and "Institutions for Mental Disease" which provided long-term nursing facility care.
- The conception about realignment was that it would be just for mental health services, and at the last minute there was pressure put on realignment to expand to other programs. Included in the realignment that was going to be funded through these new revenue sources were public health programs and some social services programs, such as in-home supportive services and foster care, were added to the realignment formula.
- Over time, this structure has contributed too many of the shortcomings of Realignment to keep pace with mental health needs.
- On the positive side, realignment has provided counties with many advantages that they didn't have before, including a stable funding source for programs, which has made a long-term investment in mental health infrastructure financially practical. In addition, it allows for the ability to use funds to reduce high-cost restrictive placements, and to place clients more appropriately in the community.
- Realignment also gave counties greater flexibility, discretion and control, including the ability to "roll-over" funds from one year to the next, enabling long-term planning and multi-year funding of projects to build the infrastructure that was desperately needed.
- Realignment placed an emphasis on a clear mission and defined target populations which has allowed counties to develop comprehensive community-based programs and systems of care to institute best practices and to focus scarce resources on supporting recovery.
- Realignment funds are distributed by formula and the way in which it works is the State collects the revenues annually. The revenues are then distributed to counties and to each of three revenue funds until each county receive funds equal to the previous year's total. The funds received above that amount are placed into growth accounts separately for both sales tax and Vehicle License Fees. The growth is a fixed amount annually and this is also the key to the crises and realignment funding for mental health, in that the first claim on the sales tax growth account goes to caseload driven social services programs and in the last few years there has not been enough growth to even fully fund the Social Services account. Any remaining growth from the Sales Tax Account then goes to the rest of the programs including health and mental health and all Vehicle License Fees growth is then distributed according to a formula developed in statute.
- Because of the Realignment formula being weighted in favor of the caseload driven accounts, mental health has not received any sales tax growth in four years and will not receive for the foreseeable future. This means that the only growth that counties will receive for mental health and health is from the Vehicle License Fee. The Vehicle License Fee growth has only averaged 2.1% a year for the past 3 years and meanwhile, costs of services and other demands have steadily risen.
    - Chair Steinberg said he will want to hear comment later on whether or not a trend is seen of that 10 percent shifting away from mental health because of Prop 63 because this would be a violation of the Act.
- Federal Medicaid dollars constitute the second largest revenue source for county mental health programs, after Realignment. This is crucial to understanding how Realignment and Medi-Cal work in order to understand the fiscal pressures on counties now.
- Going back in history, in 1971 counties agreed to take on the responsibility for managing mental health services that the federal government requires the state to provide.
- Although managing the program involves substantial administrative obligations, the new program offered a better array of mental health services. It also gave counties the

opportunity to "draw down" federal funds and therefore to serve more people in the public Medi-Cal system.

- In 1993, another major changed to the public mental health system was that California apply to the Federal Government to be approved for the Rehab Option as opposed to the Clinic Option. This allowed California to offer a wide variety of benefits under the Medi-Cal program. Prior to this the clinic option only allowed California to provide inpatient services and outpatient psychiatric and psychologist's services.
- The Rehab Option allows services that reduce the de-institutionalization and help persons with mental disabilities live in the community. There has been recent federal discussions under this current Administration about cutting the Rehab Option which would have a severe negative impact on the progress of transforming the mental health system.
- Counties were providing some Medi-Cal services up until 1995 through the county Medi-Cal system. There was also the private fee-for-service system that primarily provided inpatient and outpatient services.
    - In 1995 through 1998 the State decided that they would consolidate the two systems with the fee-for-service Medi-Cal system and created one carved out specialty mental health managed care program.
    - This program operates under a federal Freedom of Choice waiver. Each Mental Health Plan contracts with DMH to provide medically-necessary specialty mental health services to the beneficiaries of the county.
    - Currently, all Medi-Cal beneficiaries must receive their specialty mental health services through the County Mental Health plan.
    - General Mental Health care needs for Medi-Cal beneficiaries remain under the responsibility of the Department of Health Services, rather than DMH. DHS Fee for Service still covers pharmaceuticals for carve-out mental health beneficiaries.
    - The State DHS transferred the funds that it had been spending under the Fee for Service system and it was assumed that mental health plans would receive additional funds yearly beyond the base allocation for increases in Medi-Cal beneficiary caseloads and for COLAs.
    - It was assumed when the carve-out was created, that any costs beyond the allocation for the state match for Medi-Cal specialty mental health services were to come from county Realignment revenues.
    - The impact of Medi-Cal on Realignment funds is:
        - Since Medi-Cal consolidation, administrative requirements by DMH and by the Federal government have grown substantially.
        - Most importantly, counties have not received COLAs for the Medi-Cal program since 2000. In the FY 03/04 state budget, the Medi-Cal allocation to counties was actually reduced by 5% which compounds over time.
        - Cumulatively, since FY2000/01, counties have lost approximately $51 million in State General Fund which when matched with federal financial participation funds amounts to approximately $102 million due to both the lack of a COLA and the 5 percent reduction in 2003-04. So the amount of money that counties were given to manage the program has eroded.
        - The Governor's FY 2006-07 again proposes no COLA for this program. Increased program costs will once again be paid from Realignment funds.
    - Early and Periodic Screening, Diagnosis and Treatment (EPSDT) – to further complicate things, a lawsuit against the state in 1995 resulted in the expansion of Medi-Cal services to Medi-Cal beneficiaries less than 21 years of age who need

specialty mental health services to correct or ameliorate mental illnesses, whether or not such services are covered under the Medicaid State Plan.

- As a result of the settlement, the state agreed to provide SGF to counties as the match for these expanded specialty mental health services. These services qualify under the EPSDT Medi-Cal benefit and are commonly referred to as EPSDT services.
- DMH developed an interagency agreement with DHS through which county mental health plans were reimburse the entire non-federal share of cost for all EPSDT – eligible services in excess of the expenditures made by each county for such services during FY 1994-95.
- In fiscal year 2002-03, there was concern from both the Administration and the Legislature that the EPSDT program was growing too much so it was determined that a 10 percent county share of cost was to be imposed on counties to provide an incentive for counties to better manage the growth of EPSDT. Counties must now pay 10 percent of the cost of growth for EPSDT services.

o There is also another children's program that is a major part of the county delivery system, and that is AB3632 Special Education Services to Students. This is pursuant to the federal IDEA law which requires that students are given the benefit of a free and appropriate public education. In this program, the schools identify the students and create an IEP (Individualized Education Plan) and if the student is determined by the school to need an assessment for mental health services, then they refer the child to County Mental Health. Mental Health participates in the IEP Team and performs an assessment. It is then determined at that point what the student needs in order to be able to stay in school. These services are a federal entitlement, and children must receive services irrespective of their parents' income-level. Many of these students are of the same population that would be served to the extent that resources are available or through Medi-Cal, but there are students that are covered by this entitlement program that would not be part of the county's target population.

- The state, in order to comply with the IDEA law takes about $1 billion per year of federal IDEA funding and as a result they have to assure the federal government that they will comply with the federal IDEA law. In 1984 the Legislature decided that the state was not doing a very good job of serving students that had mental health problems so AB3632 was passed that transferred the responsibility for providing services for students under the IDEA in California who needed mental health services in order to benefit from their free and appropriate public education. At that time they transferred $3 million to pay for these services, but they created a mandate on counties to provide these services.
- Prior to enactment of the state's FY 2002/03 budget, a total of $12 million had been budgeted for counties statewide as a categorical program to pay for these mandated services. Counties, over the past few years, have gone through the arduous process of filing a test claim with the State Mandate's Commission in order to determine that these services are a reimbursable mandate and that the state should be paying for these services over and above what the counties get from the state. The test claim was established.
- In the FY 2002/03 state budget, the $12 million of categorical funding for counties was eliminated entirely, and counties were told that they could receive all of their funding through the mandate reimbursement

process. However, the budget also placed a moratorium on mandate reimbursements for local government.

- The state currently owes counties over $300 million in mandate reimbursement for this program alone.
- In most counties, the only revenue source available to pay for these services is Realignment revenues, which are meant to serve their "target population" not Special Education Students. Many counties are being forced to cut other programs as a result of this.
- Two years ago the Legislature decided that $69 million of federal IDEA funds would be used to help pay counties, and so for the last two years this has gone to counties and anything over and above this, counties can submit for mandate reimbursement.
- Prior to Prop 1-A, four counties sued the state and won and it was determined that for those four counties if the payment was inadequate for that year that it was no longer entitlement on them and they didn't have to pay for the services. Prop 1-A passed subsequent to this and the state acknowledges from '04-'05 going forward that they must either suspend the mandate or fully pay for that mandate. Last year they didn't suspend the mandate but they provided $60 million of mandate reimbursement for '05-'06 and '04-'05 which wasn't enough for both years so they still have deficiencies. Once they determine what the total cost is of mandate claims, then they will have to go back and find a deficiency bill to pay this.
    - Chair Steinberg asked if Ms. Ryan could report back with a definitive number of what is owed from past years in order that the Commission can see the big picture.
    - Commissioner Diaz said she continually hears from stakeholders across Los Angeles that if they could get the funding owed to them with AB3632 they would not have such a large deficit. This is a serious issue across California.
    - Commissioner Doyle said before AB3632 became law the school systems routinely ignored the mental health needs of these children and they simply were not met. AB3632 is a very good program, but the problem is it has not been financed.
    - Commissioner Feldman asked Ms. Ryan's thoughts on Realignment and whether it should go away. She said she has not ever heard county mental health directors say that Realignment should go away. She thinks what needs to be done is to take a comprehensive look at what is in Realignment and how it is funded and either find an additional revenue source or take some of the programs out that are creating pressures on other programs.
    - Chair Steinberg asked Ms. Ryan to explain how this fiscal situation has affected the county MHSA planning process. He also asked what are the nature and quality of these services. Ms. Ryan said she would defer these questions to the directors.

- While the MHSA will bring an exciting and much needed infusion of new funds into California's public mental health system, it will not fix the structural financing problems counties face.
- It is inevitable that counties will need to reduce services in their non-MHSA systems, at the same time they are building new services under MHSA.
- In conclusion, realistic expectations for this Commission, is to work together to help the general public understand what the Mental Health Services Act can and cannot do and to help them understand what the current public mental health system pressures are and what can we do or learn that we didn't have the flexibility to do before.

V. County Strategies to Transform & Address Mental Health Service Financing Challenges

Mr. Don Kingdon, Director of Shasta County gave the following presentation:

- Shasta County's budgeted expenditures for '06-'07 will exceed the budgeted revenues by 10 percent. The bulk of the reason is due to the increases in costs of long-term and short-term locked beds.
- The bulk of Shasta County's revenue comes from federal health care claims. The County is 35 percent dependent on being able to bill the federal government for federal health care claims. The second largest place the revenue comes from in Shasta County is through Realignment (29 percent). However, two-thirds of the County's Realignment is used in order to participate in the Medi-Cal program. The third largest is EPSDT and is passed through to private providers. The next is the Mental Health Services Act for '06-'07 representing an 8 percent increase in revenue for Shasta County. AB2034 represents a significant portion of revenue. The match for Medi-Cal services is shrinking in Shasta County.
- The mental health system is very categorical from a revenue perspective. Each one of the categories of revenue has its own reporting, accounting, and quality and outcome standards. This is daunting to manage.
- The Mental Health Services Act has had a tremendous impact on the community. The most important impact is it has required the County to meet with members of the community to see what can be done to make things better.
- The biggest challenge facing people with mental illness in rural communities is transportation. Another challenge is law enforcement. The Sheriff doesn't come to many parts of Shasta County, so what happens in rural areas is the issues associated with being mentally ill come to different people's attention. Misdemeanors and public nuisances are often overlooked. In addition, employment and income looks very different in rural areas. Most rural areas have unemployment rates two to three times that of the State, so there is a need to understand and provide support in urban areas. The County will have to form partnerships with local people who already have a certain amount of credibility and where people already trust to go and ask for services. The rural health clinics offer this opportunity in Shasta County and they are looking at combining psychiatry with tele-psychiatry.
- The community's experience with government and grant funded services is they see the programs come into the area and it works well, and in two or three years it is gone. So from the rural perspective it is very important that we remember sustainability and services is the only way to gain trust from these people.
    - Chair Steinberg asked Mr. Kingdon how he intends to use MHSA funding in a way to forge new partnerships that will build on other resources that are currently being utilized. Mr. Kingdom said Shasta County will be partnering with

federally qualified health clinics. However, one of the things that their funding stream does not allow them to do is field base case management. What will be added with MHSA funds is a car, a case manager and a telephone so that people needing services can be brought in to the clinics for their appointments, outreach, engagement linkage, and 24 hour response. The clinic's services will be augmented with MHSA money to fund those things that Medi-Cal will not fund in the field.

- The question was asked if Shasta County had a Native American population, and if so, if they are served well. Mr. Kingdon said there are two tribes in the area. One is very well served and they have a Casino. The other tribe is not as well served and they have significant issues associated with their rural isolation. Both tribes are interested in working with the County, particularly around the areas of case management and tele-psychiatry.
- Commissioner Poat asked Mr. Kingdon that as ideas come to him as to how the Commission can use its role to collapse the categories of revenue reporting requirements that he forward those ideas to the Commission.
- Mr. Kingdon asked if there was some way to get a better sharing of the responsibility for Medi-Cal match for adults to free up Realignment then Realignment could augment Mental Health Services Act money tremendously.

Mr. Troy Fox, Director of Merced County gave the following presentation:

- In 1991 when Realignment started there was continuous growth and an equity distribution was attached to the distribution Realignment funds.
- In 1994-95 there was the lawsuit related to EPSDT and a baseline for EPSDT was established at $1.8 million for Merced County. This means that the County had to contribute significant amounts of Realignment dollars to match EPSDT.
- In 1999 the revenues declined and Merced County had to take money out of its trust fund in order to maintain the level of services.
- Since 1999-2000 Merced County has been in a cost containment mode. To expand children's services, the adult service system has had to shrink in order to shift resources to meet the mandates for serving children.
- Merced County is not a 2034 County so it has not had the benefit of having AB2034 funds.
- 2004-05 is the first year since 1998 that Merced County's revenues were actually more than its costs. The reason for this was due to the cost containment mode over the last five years.
- It is estimated that at the end of 2006-07 the Realignment trust fund balance will be down to $1 million and for subsequent years if nothing changes, there will be no trust fund balance and more cuts will have to be made in the core system.
- The Mental Health Services Act funds will allow new programs to be built. Merced County has an extremely high percentage of Medi-Cal beneficiaries and indigent population. The homeless population, Hispanic population and Southeast Asian population are the three primary target populations in the Mental Health Services Act Plan. Dr. Mayberg has signed approval of Merced County's plan today and this will allow the County to move forward with plans to reduce disparities in the system.
- The Southeast Asian population have been engaged in the planning process. Meetings have been held with them and the County has learned about the Shaman, who are their spiritual and natural healers. Through these meetings the County has learned what their needs are and how to approach their community. Twenty-two Shaman attended and participated in the meeting. The County will be funding, through a contract with Merced

Lao Family Community, for them to have their own clinician on site to perform assessments and screening. There is now a solid partnership.

- The question was asked how stakeholders were involved in making decisions, and which stakeholders helped with the decision-making. Mr. Fox said it was both the leaders and recipients of service and their family members who were involved in the decision making. There was broad representation in each stakeholder group. Their task was to design the ideal mental health system. Once they did that, the County came back and explained that the amount of money needed for their request was not available, so they were then asked what core programs should be implemented initially with the MSA funds.
- Commissioner Prettyman asked if Merced County might have their plan available to other Counties for replication. Mr. Fox said he is starting to write the complete plan process including what they learned from the Shaman. He said once it is complete he will be happy to share with other counties.
- Commissioner Lee asked if there is another acronym for the organization other than SEACAP that would be translatable into Mong. Mr. Fox said he has not gone that far. He has asked them to name their program. Commissioner Lee asked what the two indicators of success would be after a year of operation. Mr. Fox said the continued engagement of the Mong consumers in the system would be one indicator. Another indicator would be building the consumer family involvement in the system.
- Chair Steinberg asked about the COPE program. Mr. Fox said the second largest target population in the Mental Health Services Act in Merced County is the Hispanic population. Every Hispanic consumer and family member was invited to a meeting (plática). Fifty consumers attended the meeting and conversations took place regarding what their needs were. One of their comments was that the County needed to provide services in places they are more comfortable going to because they do not like going to the clinic. In response to their comments a mobile service system has been created, and the COPE program is the core of that system. This program is linked to the Wellness Center as well. The major outreach is to go out and identify people in the community, including homeless, and get them into the system.
- Commissioner Diaz said the Hispanic Latino culture likes to be kept in the loop and follow-up is important. Mr. Fox said they will invite them back every three months for a conversation to see if the mental health system is meeting their needs.
- Commissioner Henning asked what he sees as some of the barriers for the Hispanic penetration rates. Mr. Fox said the language barrier is critical. Commissioner Henning asked what is being done to address the language barrier. Mr. Fox said a two-tiered training program has been instituted for interpreters. There will be a 5 percent differential of pay for those interpreters who pass the training program test. His goal is to minimize the role of interpreters in the County's system by hiring as many bilingual staff as possible.
- Commissioner Jaeger said he was struck by how the programs for the two populations are so very different. He asked if the Hispanic population are not comfortable going to the mental health clinic or is it the broad medical health clinic they were referring to. Mr. Fox said the Hispanic population does not like going to the mental health clinics.

Nancy Pena the Mental Health Director for Santa Clara County gave the following presentation:

- Handouts were shared with the Commissioners describing the process, plans and informational material for the Santa Clara County plan.
- At the local level, despite the context of budget cuts, enthusiasm is thriving and the community wants to participate.
- A broad based community involvement process has been used and 10,000 voices were brought in to Santa Clara County through this process.
- Mental health directors learned early-on that they needed to step out front and be leaders. They also have the obligation to engage the local consumers and family members, as well as the system partners and providers in the process in order to frame a collective purpose for this transformation.
- In Santa Clara County there has been four phases designed for the planning process and they are now moving into implementation. The first phase was engagement and commitment. Illustrating disparities to the stakeholders was important in order to look at how to shift the inequities so that services can be accessed by those who need it. Ms. Pena explained the engagement process and how the meetings and groups were set up.
    - One of the challenges is keeping people engaged. Maintaining communication with everyone as Santa Clara County goes through the implementation process is important.
- Santa Clara is facing a huge budget shortfall. Some of the County Board of Supervisors are getting pessimistic and wondering why dollars cannot be used for gap filling.
    - Commissioner Gayle said he feels Santa Clara County's plan is fabulous, but one of his concerns as a consumer on the Commission, is that the plans need to have the consumer family leadership and honor them as a partners. The other concern is the cultural competence and the need for African American clinicians. He challenged the counties to think out of the box and not stick with traditional ideas.
    - Commissioner Henning said it is discouraging that the Hispanic population is underserved and asked what is being done to approach this problem. Ms. Pena said the Latina access is an issue across the state. The services that the Latino population wants to access is not available and there needs to be much more interface between mental health and primary care physicians in terms of finding individuals who are not interested in going to a mental health clinic. The problem in Santa Clara County for Hispanics is outreach, engagement and design of service. This is a challenging population because Hispanics are not going to come into a traditional mental health setting for services. Part of the problem is that the call center cannot find slots for people who are Spanish speaking because there are waiting lists that are one month long.

VI. Recommendations for Addressing CA Mental Health Financing Challenges & Discussion

Dr. Arneill-Py provided the following presentation:

- One of the long standing challenges is Realignment. The per capita funding among counties varies greatly and this variability results in less access to services among poorly funded counties. The mechanisms that have been in place to try to create this variability is slow to affect changes. In addition we can't expect much growth in Realignment and this will be an ongoing difficulty.
- The Planning Council has spent a great deal of time talking about the issue of the uninsured and the affect this has on trying to meet the needs of clients in the system. The erosion of Realignment funding means that resources are not available to serve indigent adults. The irony is that Realignment funding is a

revenue source that decreases as the economy becomes worse and this is at the same time that the number of uninsured would increase because unemployment gets worse.

- Another problem is the affect that under-funding has on the mental health workforce. Counties and community-based agencies are trying to implement their CCS plans, but there are concerns about the inability to implement them because of the lack of staffing. In addition inadequate salaries that are offered to mental health workers is a major barrier to try to recruit and retain a workforce.
- The federal government is talking about clarifying allowable services that are available under Medicaid. The government is trying to save $225 million in federal fiscal year 2007 and $2.3 billion over five years. This could decimate the rehab option. What is particularly frightening about this is that they are potentially talking about doing this administratively with regulations and without Congressional action. This is why advocacy is needed both within the administration and congressionally. Everyone should be working through their respective national advocacy organizations on this issue.
- In terms of Medicare reforms, this in itself is a parity issue because outpatient health services have a co-payment that is at a 20 percent rate, but for psychotherapy it is at a 50 percent co-payment rate. There is also a need to expand coverage within Medicare to get more community-based services covered. The specialty inpatient psychiatric care has a life time limitation of 120 days which is unrealistic for someone with a serious mental illness.
- There is a National Parity Act which basically provides annual and life time limits. It has a rolling sunset that is now up to December 2006. She is trying to pass the Wellstone (?) Act which would give a truer parity.
- There is a new threat on the horizon in the form of S1955 which would override all state insurance mandates and allow insurers to circumvent state parity laws. It is now headed to the Senate Floor in the first week of May.
    - Chair Steinberg said there is another issue regarding parity that deserves the attention of the Commission and it is the leveraging opportunities. How are we trying to integrate the dollars we have in the Act with the limited coverage that is provided under private insurance and what can we do to coordinate the public and private systems in a more effective way?
- One of the goals of the State Parity Statute was to try and decrease the financial burden on the public mental health system, but unfortunately this hasn't worked as well as hoped. The state just released a report. Some of the issues in the report speaks to the fact that there is a lack of clarity for consumers regarding the scope of covered services and there are problems obtaining service authorizations. The access issues are problems in obtaining information about benefits that are covered and then the issue of phantom providers. The public mental health system ends up becoming a provider of last resort and then when they try to obtain reimbursement from consumers they find it very difficult to do so. The solution for dealing with this issue is that the California Coalition for Mental Health is taking the lead and has provided significant advocacy for dealing with these problems. Managed mental health care simply does not have the enforcement options that it should to deal with private insurers and so they will be looking at Legislative solutions.
    - The other issue is there are regulations that have been in the pipeline for some time to try to improve the enforcement tools that the Department has and they are being revised in order to make them more effective.

- Recommendation of state reforms: (1) align Medi-Cal reimbursement requirements with the recovery philosophy; (2) implementing evidence based practices; (3) promoting community-based services.
    - The guidance to keep in mind is if service reductions have to occur the following principles should be kept in mind in trying to preserve the services: (1) services should be client and family driven, strength based and based on recovery and wellness philosophies; (2) care should be culturally and linguistically competent and consider all the factors; (3) there should be no disparities for individuals or groups in accessibility, availability or quality of mental health services provided.
- One of the basic principles of financial reform is that the financial structure and incentives must align with the system outcomes. The goal is that every person or family would have a family-centered recovery, resiliency oriented, culturally appropriate plan that would maximize Medi-Cal reimbursement. It will be possible to achieve this goal within the current federal statutory framework and state regulations.
    - Chair Steinberg asked if some point in the future the Council may be able to provide a road map that would allow some significantly larger percentage of Shasta County Mental Health dollars to be spent in a manner that is consistent with transformation and the Mental Health Services Act. Dr. Arneill-Py said the Medi-Cal 35 percent part of the pie that is matched by the Realignment dollars should be able to be spent in a way that is completely consistent with the goals of recovery, etc.
- The next issue is implementing evidence based practices. The Institute of Medicine defines evidence based practices as the integration of the best research evidence with clinical expertise and patient values. The California Institute for Mental Health has adapted this definition in California. Traditionally, evidence based practice research has not looked at recovery and resilience because this is an emerging concept. It has not looked at cultural competence because evidence based practices have not been done with ethnic populations. So it is important to look at various levels of scientific evidence.
    - Evidence based practices is cost-effective and it guarantees that expenditures are continued on programs and services that prove effective.
- The final point is to promote community based services. It is important to follow the lessons learned from wrap-around programs for children and youth. It is also essential to expand the availability of affordable housing. The Commission's initiative to develop housing in the state is certainly important. Focusing on transitioning clients out of institutions is something that everyone should keep in mind. The Mental Health Services Act should be used to expand the number of counties with uldred systems of care.
- In conclusion, there are some long-standing challenges that will remain, but there are opportunities for federal advocacy that are significant and should be pursued to prevent adverse consequences to Medicaid. There are also state reforms that can continue to bring positive results for clients and families.
    - Ms. Wynne asked if the National Association of Governors are playing an active role in the federal advocacy and is California part of that. Dr. Arneill-Py said the National Association of Governors are difficult to deal with on the Medicaid issue because they advocate for more flexibility and she is not sure what their advocacy is on some of the

reductions. She believes that California is in the position to roll back all of its optional services except for EPSDT.

- Chair Steinberg asked if Dr. Arneill-Py could report back to the Commission on the road map to be used in order to begin accomplishing some of the things she has identified.

The meeting was adjourned.

Minutes approved: 5/27/06